Aetna

Side 1

EMPLOYEE MEDICAL LEAVE REQUEST

REFER TO THE INSTRUCTIONS BEFORE COMPLETING THIS FORM		
1. Employee's Name (last, first, middle initial)	2. Aetna ID	3. Mail Location Code
4. Home Address (Number, Street, City, State, Zip Code)		
5. Work Telephone Number ( ) -	6. Adjusted Date of Hire	
7. Manager's Name	8. Manager's Telephone Number ( ) -	9. Manager's Mail Loc. Code
10. Check scheduled work days: ☐S ☐M ☐T ☐W ☐T ☐F ☐S	11. Check here if you are requesting Employee Medical Leave because you do not qualify for or were denied managed Short-term Disability (STD) benefits: ☐	
12. Have you been approved for Workers' Compensation? ☐ Yes ☐ No Workers' Compensation Claim Number	13. Line of Business AFS ☐ Aetna International ☐ AUSHC ☐ Aetna Corporate ☐	
14. If requesting Employee Medical Leave on an intermittent or reduced leave schedule basis, specify the days and/or hours for which you are requesting intermittent leave or a reduced schedule.		
15. Length of Leave (e.g., 6 weeks)	16. Dates of Absence FROM _____/_____/_____ THROUGH _____/_____/_____	
I understand that if it is determined that I am not eligible for Employee Medical Leave under Aetna's Family and Medical Leave policy or any applicable federal/state/local leave laws or other Aetna policy, my absences may be counted for attendance disciplinary purposes. I authorize Aetna's authorized representative to contact my health care provider in the event the medical information submitted to Aetna by my provider in support of my request for Employee Medical Leave needs clarification or authentication.		
17. Employee's Signature	18. Date Employee Requested Employee Medical Leave	
19. Manager's Signature	20. Date Employee Requested Employee Medical Leave	

MAIL OR FAX COMPLETED FORM TO:

Employee Medical Leave
Total Health and Disability Services (TH & DS), REAH
Aetna Services, Inc.
151 Farmington Avenue
Hartford, CT 06156
FAX: 1-860-273-7397

IF YOU HAVE QUESTIONS, CALL TH & DS AT 1-800-AETNA-HR (1-800-238-6247)

Manager: Give a completed and signed copy of this form to the employee. Place a copy in the employee's personnel file.

Aetna

Side 1

STATEMENT OF HEALTH CARE PROVIDER

(Items 2-12 are to be completed by the health care provider only.)

Please provide only that information which relates to the condition for which the employee is taking leave.

1. a. Employee's Name	b. Aetna ID	c. Mail Location Code

2. Side 2 of this form describes what is meant by a "**serious health condition.**" Does the employee's condition qualify under any of the categories described? If so, please check the applicable category.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

OR, None of the above (the employee does not have a serious health condition) ☐

3. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories on the reverse side of this form:

4. a. Approximate date the employee's condition began:

b. Probable duration of the condition:

5. Please list the specific dates on which the employee was (or will be) absent due to this condition:
Full days:

Partial days:

6. Will it be necessary for the employee to work only intermittently or to work on less than a full-time basis as a result of the condition (including for treatment described in items 8-11 below)?

☐ Yes ☐ No If Yes, give the probably duration:

7. If the condition is a **chronic condition** (category #4) or **pregnancy**, state whether the employee is *presently* incapacitated* and the likely duration and frequency of episodes of incapacity* (e.g., 4 hours a week over the next 3 months) :

8. If **additional treatments** will be required for the condition, provide an estimate of the probable number of the treatments:

9. If the employee will be absent from work because of **treatment on an intermittent basis or part-time basis**, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

10. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

11. If a **regimen of continuing treatment** by the employee is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

12. a. Is the employee **unable to perform work of *any* kind?** ☐ Yes ☐ No

b. If the response to a., above is No, is the employee **unable to perform one or more of the essential functions of his/her job?**

☐ Yes ☐ No If Yes, please list the functions the employee is unable to perform:

c. Would the employee be able to perform this function(s) if his/her work restrictions could be accommodated?

☐ Yes ☐ No If Yes, please list possible accommodations:

d. If neither (a), (b) nor (c) applies, is it necessary for the employee to be absent from work for **treatment**?

☐ Yes ☐ No

PLEASE READ AND SIGN SIDE 2 OF THIS FORM.

Patient Name: _____

HEALTH CARE PROVIDER: REFER TO THESE DEFINITIONS WHEN COMPLETING SIDE 1 OF THIS FORM.

A "**Serious Health Condition**" means an illness, injury, or physical or mental condition that involves one of the following:

1. *Hospital Care*

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical facility, including any period of incapacity* or subsequent treatment in connection with or consequent to such inpatient care.

2. *Absence Plus Treatment*

(a) A **period of incapacity* of more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(1) **Treatment** two or more times** by a health care provider, by a nurse or physician's assistant under the supervision of a health care provider, or a provider of health services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a **regimen of continuing treatment***** under the supervision of a health care provider.

3. *Pregnancy*

Any period of incapacity* due to **pregnancy**, or for prenatal care.

4. *Chronic Conditions Requiring Treatments*

A chronic condition which:

(a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under the direct supervision of a health care provider;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition; **and**

(c) May cause episodic rather than a continuing period of incapacity* (e.g., asthma, diabetes, epilepsy, etc.).

5. *Permanent/Long-Term Conditions Requiring Supervision*

A period of incapacity which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include a severe stroke, Alzheimer's, or the terminal stages of a disease.

6. *Multiple Treatments (Non-Chronic Conditions)*

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or injury, or for a condition that would likely result in a period of incapacity* of more than three consecutive days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy) or kidney disease (dialysis).

***"Incapacity" means inability to work or perform other regular daily activities due to a serious health condition or due to treatment for or recovery from a serious health condition.**

****"Treatment" includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations or dental examinations.**

*****A "regimen of continuing treatment" includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.**

Name of Health Care Provider (print)	Type of Practice
Signature of Health Care Provider	Date
Address	Telephone Number & FAX Number

MAIL OR FAX COMPLETED FORM TO:
Employee Medical Leave
Total Health and Disability Services (TH & DS), REAH
Aetna Services, Inc.
151 Farmington Avenue
Hartford, CT 06156
FAX: 1-860-273-7397
IF YOU HAVE QUESTIONS, CALL TH & DS AT 1-800-AETNA-HR (1-800-238-6247)

INSTRUCTIONS FOR COMPLETING SIDES 1 AND 2 OF THE *EMPLOYEE MEDICAL LEAVE (EML) REQUEST AND ACKNOWLEDGEMENT* FORM

- Request consideration for Employee Medical Leave (EML) protection for a ***serious health condition*** at least 30 days before your leave begins, if the need for leave is foreseeable. Otherwise, request consideration for EML protection within a reasonable time, but *no later than two business days after the date you return to work following the leave.*

- **For absences of 6 or more consecutive work days**, you must call 1-800-AETNA-HR (1-800-238-6247) to report the absence. Any part of your absence that is certified for managed short-term disability (STD) benefits *automatically* will be considered medically certified for EML. *Do not fill out Side 1 of the EML REQUEST AND ACKNOWLEDGMENT form.* Even though managed STD benefits, if approved, do not begin until the 6th consecutive work day of your disability, your absence will be considered medically certified and, *if you are eligible for Employee Medical Leave*, your protected leave will begin *as of the first day of your disability*. Upon receipt of a notice of disability, your manager will complete Side 2 of the *EML REQUEST AND ACKNOWLEDGMENT* form to acknowledge your request for EML protection and advise you of your eligibility for leave. *Medical certification alone does not determine your eligibility for Employee Medical Leave.*

- **If your absence is not certified for managed STD benefits** (i.e., you did not meet the STD waiting period or STD benefits were denied) you must medically certify the absence separately to obtain EML protection. Complete and sign Side 1 of the *EML REQUEST AND ACKNOWLEDGEMENT* form, making sure to include the date of your leave request. Your manager also must sign Side 1 and indicate the date of your leave request. He or she then will review your eligibility for leave under Aetna's Family and Medical Leave policy and applicable local/state/federal leave laws.

  ➡ *If you do not meet the eligibility requirements for leave*, your manager will complete Side 2 of the *EML REQUEST AND ACKNOWLEDGMENT* form to acknowledge your leave request and advise you of your ineligibility.

  ➡ *If you do meet the eligibility requirements for leave*, you must have your health care provider complete a *STATEMENT OF HEALTH CARE PROVIDER* form. Mail or FAX the completed and signed *EML REQUEST AND ACKNOWLEDGMENT* form (Side 1 only) *and* *STATEMENT OF HEALTH CARE PROVIDER* form to:

Employee Medical Leave
Total Health and Disability Services (TH & DS), REAH
Aetna Services, Inc.
151 Farmington Avenue
Hartford, CT 06156
FAX: 1-860-273-7397

TH & DS must receive these forms within 15 calendar days of the date you requested leave; otherwise, your request for leave may be denied. Upon receipt of notice from TH & DS that your absence has/has not been medically certified for EML, your manager will complete Side 2 of the *EML REQUEST AND ACKNOWLEDGMENT* form to acknowledge your request and advise you of your eligibility for leave. *Medical certification alone does not determine your eligibility for Employee Medical Leave.*

- If you have time available in your PTO Bank, you must use that time concurrently with any unpaid portion of your approved Employee Medical Leave. Any PTO Bank time taken in conjunction with an unpaid Employee Medical Leave will count toward your 16 weeks per rolling 12-month period of protected leave.

- Your health, life and disability benefits will continue during your certified and approved leave. If your leave is unpaid, however, you are responsible for paying your employee contribution for these benefits each month. Contact the HR Service Center at 1-800-AETNA HR (1-800-238-6247) for information about making these payments. If you fail to make these contributions and decide not to return to work at the end of your leave, you may be legally responsible for the payment of both your share and Aetna's share of the contributions during the leave.

- During unpaid leave, you forfeit one month of PTO Bank accrual for each 20 consecutive work days that you are on leave. (California employees: See your local HR professional.) For details on how benefits are affected during unpaid leave, see the Employee Benefits Handbook and Summary Plan Description. If you are on a certified and approved Employee Medical Leave and initially are not certified for managed STD benefits, you will be eligible to apply for STD and may be eligible for managed LTD benefits once your physician provides acceptable medical certification of your disability.

- At the end of your statutory and mandatory Aetna Employee Medical Leave, you have the right to be restored to your same job or an equivalent position with equivalent pay, benefits and other terms and conditions unless your employment would have terminated regardless of your legitimate use of leave. You are not guaranteed reinstatement at the end of a discretionary leave of absence.

For more information about Aetna's Family and Medical Leave policy, talk to your manager or local Human Resources professional. You also may contact Total Health and Disability Services at 1-800-AETNA HR (1-800-238-6247).

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Side 2

EMPLOYEE MEDICAL LEAVE ACKNOWLEDGEMENT

(To be completed by the manager to acknowledge an employee's request for Employee Medical Leave)

REFER TO THE INSTRUCTIONS BEFORE COMPLETING THIS FORM

To: (Employee's Name)	From: (Manager's Name)	Date:

Part I. Check one of the following:

☐ I have received a notice of disability which indicates that you have been certified and approved for managed short-term disability benefits. I also have reviewed your leave eligibility and allotment under the federal Family and Medical Leave Act, applicable state and local leave laws, and Aetna's Family and Medical Leave (FML) policy.

OR

☐ I have received your request for **Employee Medical Leave** (EML) protection for the period(s) specified in items 12., 13. and 14. on Side 1 of this form and reviewed your leave eligibility and allotment under the federal Family and Medical Leave Act, applicable state and local leave laws, and Aetna's Family and Medical Leave (FML) policy. *(Delete the next sentence if employee is not eligible for leave (e.g., has less than 12 months of service)and therefore has not sought medical certification.)* I also have received notice from Total Health and Disability Services which indicates that your absence *(select one)* has/has not been medically certified for Employee Medical Leave protection.

Part II. Check appropriate responses below and give a copy of this acknowledgment to the employee.

On the basis of my review:

1. ☐ You are not eligible for leave under Aetna's FML policy because:

   a. ☐ You do not meet the eligibility requirements for leave (1,000 of work in the 12 months before leave begins and 12 months of service).
   I anticipate that you will meet these eligibility requirements on ____/____/____ (date).

   b. ☐ You previously exhausted your FML allotment of 16 weeks. I anticipate that you will be eligible for leave again on ____/____/____ (date).

   c. ☐ Other (specify, e.g., failure to request leave within two business days of return to work, lack of medical certification, etc.):
   _____

2. ☐ You are not eligible for leave under Aetna's mandatory policy but you are eligible for leave under state/local law. Your _____ hours/days/weeks of leave will be counted as both state/local statutory leave and Aetna FML leave.

3. Your absence has been medically certified for Employee Medical Leave protection.

   a. ☐ The following time will be counted against your leave allotment under Aetna's FML policy and/or applicable federal, state and local law:
   List days/weeks of certified Employee Medical Leave:
   _____

   b. ☐ You are eligible for leave on an intermittent basis, as follows *(specify frequency/duration of intermittent leave)*. This time will be counted against your leave allotment under Aetna's FML policy and/or applicable federal, state and local law:
   List hours/days/weeks of certified intermittent Employee Medical Leave:
   _____

   c. ☐ You are eligible for a reduced leave schedule, as follows *(specify the reduced leave schedule and the period for which it is certified)*.
   This time will be counted against your leave allotment under Aetna's FML policy and/or applicable federal, state and local law:
   List hours/days/weeks of certified reduced leave schedule:
   _____

Any additional time that is medically certified for Employee Medical Leave protection also will be counted as statutory and Aetna FML leave until you have used 16 weeks of leave in a rolling 12-month period. You may be required to provide additional medical certification to support your need for additional leave. Failure to submit additional medical information within 15 calendar days of a request for this information or to provide adequate medical information may result in treatment of your leave as not legally protected. Be sure to review the department's attendance policy to determine when unscheduled, unprotected absences will result in disciplinary action.

_____
Manager's Signature

Manager: Give a completed and signed copy of this form to the employee.
Place a copy in the employee's personnel file.

INSTRUCTIONS FOR COMPLETING SIDES 1 AND 2 OF THE *FAMILY LEAVE AND FAMILY MEDICAL LEAVE REQUEST AND ACKNOWLEDGEMENT* FORM

- Request consideration for Family Leave or Family Medical Leave protection at least 30 days before your leave begins, if the need for leave is foreseeable. Otherwise, request consideration for protected leave within a reasonable time, but *no later than two business days after the date you return to work following the leave.*

- Complete and sign Side 1 of the *FAMILY LEAVE AND FAMILY MEDICAL LEAVE REQUEST AND ACKNOWLEDGEMENT* form, making sure to include the date of your leave request; your manager also must sign Side 1 and indicate the date of your leave request. He or she then will review your eligibility for leave under Aetna's Family and Medical Leave policy and applicable federal/state/local leave laws.

  - ***If you do NOT meet the eligibility requirements for leave***, your manager will complete Side 2 of the *FAMILY LEAVE AND FAMILY MEDICAL LEAVE REQUEST AND ACKNOWLEDGMENT* form to acknowledge your leave request and advise you of your ineligibility.

  - ***If you meet the eligibility requirements for leave, and your request is for Family Leave***, your manager will complete Side 2 of the *FAMILY LEAVE AND FAMILY MEDICAL LEAVE REQUEST AND ACKNOWLEDGMENT* form to acknowledge your leave request and advise you of the time that will be counted against your leave allotment.

  - ***If you meet the eligibility requirements for leave, and your request is for Family Medical Leave,*** you must provide medical information from your eligible family member's health care provider that indicates the family member has a ***serious health condition***. Have your family member's health care provider complete a *FAMILY MEDICAL LEAVE STATEMENT OF HEALTH CARE PROVIDER* form and submit this to your manager. If the form indicates a serious health condition, your manager then will complete Side 2 of the *FAMILY LEAVE AND FAMILY MEDICAL LEAVE REQUEST AND ACKNOWLEDGMENT* form to acknowledge your leave request and advise you of the time that will be counted against your leave allotment. *Your manager must receive the FAMILY MEDICAL LEAVE STATEMENT OF HEALTH CARE PROVIDER within 15 calendar days of the date you requested leave; otherwise, your request for Family Medical Leave may be denied.*

- If you have time available in your PTO Bank, you may elect to use that time concurrently with any unpaid portion of your Family Leave or Family Medical Leave. Any PTO Bank time taken in conjunction with an unpaid Family Leave or Family Medical Leave will count toward your 16 weeks of protected leave per rolling 12-month period.

- Your health, life and disability benefits will continue during your approved paid leave. If your leave is unpaid, however, you are responsible for paying your employee contribution for these benefits each month. Contact the HR Service Center at 1-800-AETNA HR (1-800-238-6247) for information about making these payments. If you fail to make these contributions and decide not to return to work at the end of your leave, you may be legally responsible for the payment of both your share and Aetna's share of the premium contributions during the leave.

- During any unpaid leave, you will forfeit one month of PTO Bank accrual for each 20 consecutive work days that you are on leave. (Calif. employees: see your local HR professional.) For details on how benefits are affected during unpaid leave, refer to your Employee Benefits Handbook and Summary Plan Description. If you become disabled while on an unpaid Family Leave, Family Medical Leave, or discretionary leave of absence, you are not eligible for managed short-term disability or managed long-term disability benefits.

- At the end of your statutory and mandatory Aetna Family Leave or Family Medical Leave, you have the right to be restored to your same job or an equivalent position with equivalent pay, benefits and other terms and conditions unless your employment would have terminated regardless of your legitimate use of leave. You are not guaranteed reinstatement at the end of a discretionary leave of absence.

For more information about Family Leave or Family Medical Leave under Aetna's Family and Medical Leave policy, talk to your manager or local Human Resources professional. You also may call 1-800-AETNA-HR (1-800-238-6247).

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